This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.springfieldmo.gov/departments/hr.html** or by calling **(417) 864-1607**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers $500 person/ $1,000 family For out-of-network providers $1,000 person/ $2,000 family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over on January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	For in-network providers $2,500 person/ $5,000 family For out-of-network providers $7,000 person/ $14,000 family	The **out-of-pocket limit (deductible + coinsurance)** is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses. For prescription drug coverage out-of-pocket maximums, please see chart on page 2.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, RX copays, penalties and health care expenses this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. For prescription drug coverage out-of-pocket maximums, please see chart on page 2.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See http://healthplan.mercy.net/healthplans/dyn_EmployerProviderSearch.aspx?emp=City%20of%20Springfield for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary on the City's web site or on www.dol.gov/ebsa/healthreform web site, or you can obtain a copy by calling the above number.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductible**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	----------none----------
	Specialist visit	20% coinsurance	40% coinsurance	----------none----------
	Other practitioner office visit	20% coinsurance	40% coinsurance	Chiropractic care limited to MD or DO
	Preventive care/screening/immunization	0%	40% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$5 copay + 20% of the remainder of the total cost per 30-day supply	40% coinsurance	Mandatory Generic program applies. Maximum of $4,100 out-of-pocket (copays +20% share in-network) per person or $8,200 per family / per Calendar Year then 100% paid by plan.
	Preferred brand drugs			
	Non-preferred brand drugs			

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
www.springfieldmo.gov/departments/hr.html	Specialty drugs	20% copay per 30-day supply.	Not applicable	Must be obtained through the Specialty Drug provider. Maximum of $1,500 out-of-pocket per Calendar Year then 100% paid by plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	20% coinsurance	For emergent: 20% coinsurance For non-emergent: 40% coinsurance	$100 penalty per visit is applied if the person uses the Emergency Room for non-emergent services.
	Emergency medical transportation	20% coinsurance	For emergent: 20% coinsurance For non-emergent: 40% coinsurance	----------none----------
	Urgent care	20% coinsurance	40% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance at the semiprivate room rate	40% coinsurance at the semiprivate room rate	Benefit payment will be reduced by $100 if the stay is not precertified.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	----------none----------
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	----------none----------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	----------none----------
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Two ultrasounds will be considered an eligible expense for a routine Pregnancy.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 visits per Calendar Year maximum
	Rehabilitation services	20% coinsurance	40% coinsurance	----------none----------
	Habilitation services	Not covered.	Not covered.	Not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	At the facility's semiprivate room rate. 60 days per Calendar Year maximum
	Durable medical equipment	20% coinsurance	40% coinsurance	----------none----------
	Hospice service	20% coinsurance	40% coinsurance	90 days per Calendar Year maximum
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	Routine exam not covered.
	Glasses	Not covered.	Not covered.	Not covered unless following eye surgery.
	Dental check-up	Not covered.	Not covered.	Dental care not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other excluded services.)

- Acupuncture
- Chiropractic Care by chiropractors
- Cosmetic Surgery
- Dental Care
- Habilitative Services
- Hearing Aids, except for dependent children as required under Missouri State Statutes
- Infertility Treatment
- Long-term care (other than medically necessary skilled nursing care)
- Routine Eye Care (including exam) and glasses (Limited coverage exceptions apply.)

Other Covered Services (This isn't a complete list. Check your plan document for details on each, other covered services and your costs for these services.)

- Bariatric Surgery (criteria applies).
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing (criteria applies).
- Routine Foot Care (i.e., for diabetics)
- Weight loss programs (criteria applies).

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (417) 864-1607. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The City's Human Resources department at (417) 864-1607 or Med-Pay's Customer Service department at (417) 886-6886 or (800) 777-9087. Additionally, a consumer assistance program can help you file your appeal. Contact the Missouri Department of Insurance, 301 W. High Street, Room 830, Jefferson City, MO 65101, (800) 726-7390, www.insurance.mo.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,320
- **Patient pays** $2,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles (Mother + Baby)	$1,000
Copays	$20
Coinsurance (Mother + Baby)	$1,100
Limits or exclusions	$120
Total	**$2,240**

You may file for reimbursement of these expenses, as permitted by the City's Flexible Spending Account Plan.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,310
- **Patient pays** $2,090

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$1,200
Coinsurance	$400
Limits or exclusions	N/A
Total	**$2,100**

You may file for reimbursement of these expenses, as permitted by the City's Flexible Spending Account Plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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